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Great Suffering, Great Compassion: A Transcultural Opportunity for School Nurses Caring for Cambodian Refugee Children

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ABSTRACT

The unique cultural ways of Cambodian refugee families, combined with the physical and psychological health problems inherent in their refugee experience, present challenging and rewarding opportunities for school nurses to engage in the process of transcultural nursing. The authors discuss the profound and devastating impact of the refugee experience upon the mind, body, and spirit of Cambodian children. The purpose of this exploratory and descriptive study was to understand the nature and meaning of a school district's cross-cultural team's experiences of providing health care for Cambodian refugee children. Focus group interviews of school nurses and Cambodian liaisons were conducted, utilizing Dobson's (1989) conceptual framework of transcultural health visiting as a guiding theoretical perspective. The concepts of transcultural and intracultural reciprocity as experienced with Cambodian refugees were explored and described in this qualitative study. The multifaceted roles of Cambodian liaisons emerged as vital components to successful connections with Cambodian refugee families.

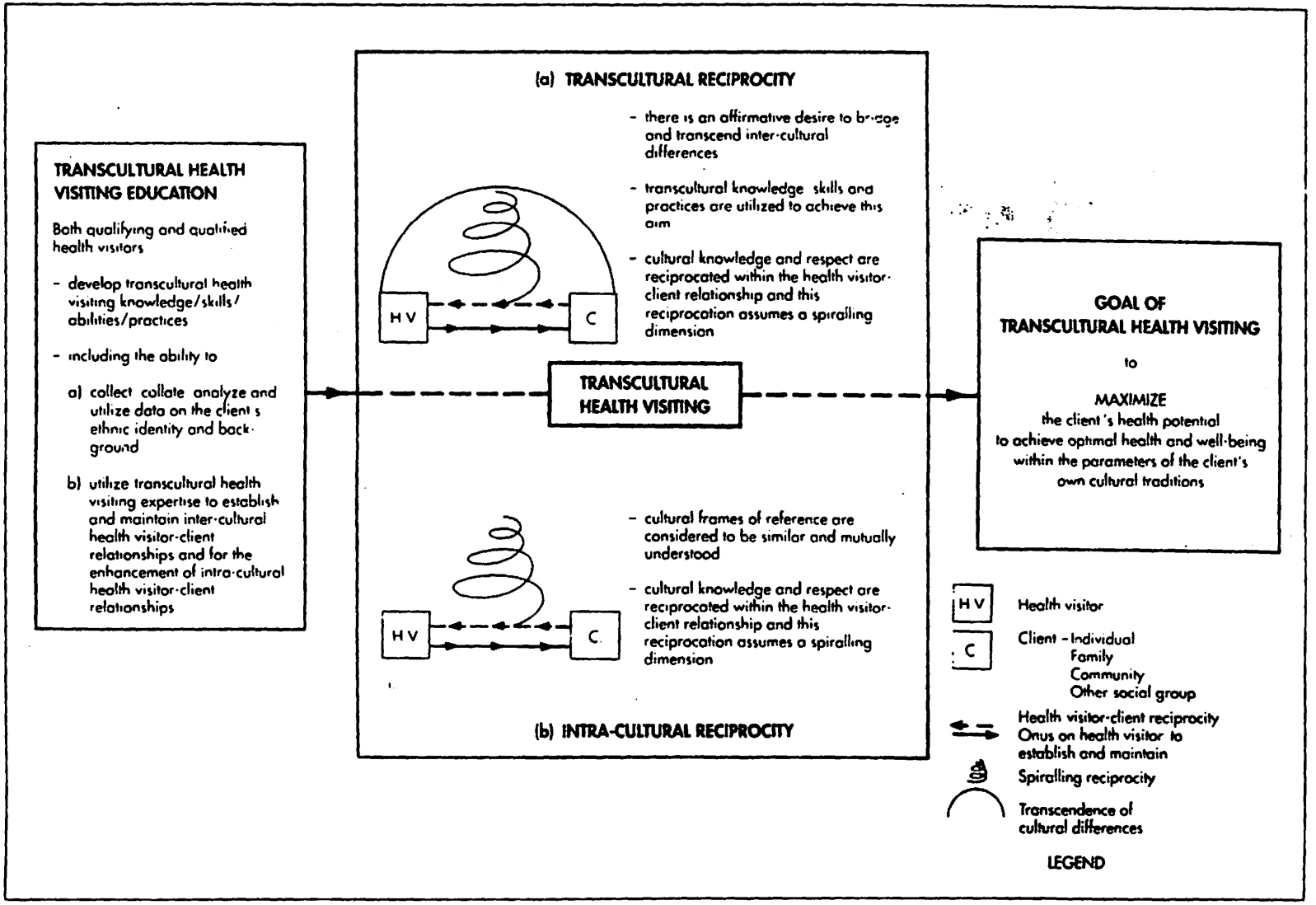

Fig. 14 Transcultural health visiting-schema–Dobson

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Abstract

The unique cultural ways of Cambodian refugee families, combined with the physical and psychological health problems inherent in their refugee experience, present opportunities for nurses to engage in transcultural nursing. The purpose of this exploratory and descriptive study was to understand the nature and meaning of a school district's cross-cultural team's experiences of providing health care for children of Cambodian refugee families. Focus group interviews with school nurses and Cambodian liaisons were conducted, utilizing Dobson's (1989) conceptual framework of transcultural health visiting as a guiding theoretical perspective. Transcultural and intracultural reciprocity as experienced with Cambodians are explored and described. Concrete suggestions for fostering transcultural reciprocity with Cambodian refugee families are provided.

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Introduction

In the early 1980's large numbers of Cambodian refugees began arriving in the United States in the aftermath of Pol Pot's communist Khmer Rouge regime. The genocide of an estimated 1 to 3 million Cambodians, out of the country's population of 7 million, took place between 1975 and 1979. Executions, starvation, brutal labor camps, and separation of children from their families, characterized the atrocities Cambodians endured during this period. After the Vietnamese invasion of Cambodia in 1978, hundreds of thousands of Cambodian refugees fled to refugee camps in Thailand, arriving with legacies of unfathomable suffering and trauma. It is from these camps that Cambodian refugees came to the United States.

The unique cultural ways of Cambodian refugee families, combined with the physical and psychological health problems inherent in their refugee experience, have presented challenging and rewarding opportunities for school nurses to engage in the process of transcultural nursing. The purpose of this exploratory and descriptive study was to understand the nature and meaning of a school district's cross-cultural team's experiences of providing health care for children of Cambodian refugee families. Focus group interviews of school nurses and Cambodian liaisons were conducted, utilizing Dobson's (1989) conceptual framework of transcultural health visiting as a guiding theoretical perspective. The concepts of transcultural and intracultural reciprocity, as experienced in relationships with Cambodian refugees, were explored.

Historical Background

Cambodian refugees were part of a larger flood of Southeast Asian refugees which began entering the United States in 1975 in the aftermath of war and oppressive political regimes (Carlson & Rosser-Hogan, 1993). Between 1975 and 1995, 146,346 Cambodians resettled in America (Office of Refugee Resettlement, 1995). California has been the primary site for Cambodian refugee resettlement, followed by Texas, Washington, and Massachusetts. Approximately half of

the Cambodian refugees arriving between 1982 and 1991 were children under the age of 18 years (Office of Refugee Resettlement, 1991).

The communist Khmer Rouge regime "struck at the fabric of traditional Cambodian life by destroying contact with the past, the religion, the educational system, and the family" (Kinzie & Sack 1991, p. 92). Buddhist monks and nuns were killed and sacred pagodas were desecrated and destroyed. The Khmer Rouge systematically targeted educated professionals and urban dwellers for execution in their quest for a classless society (Miller, 1995). Professors, nurses, doctors were murdered due to their higher educational and professional status, consequently Cambodian refugee families who came to the United States often originated from rural areas. Many were uneducated and illiterate in their own Khmer language. (Khmer refers to either the Cambodian people or language--it is not to be confused with the term Khmer Rouge, the name given the Cambodian communist faction associated with Pol Pot.) Forced separation of husbands, wives, and children took place in the labor camps, so many women arrived as widows.

Prior to arrival in the United States, Cambodian refugees may have lived several years in Thailand's overcrowded refugee camps. Limited medical and nutritional resources in the camps provided less than even basic care. Crime and rape by Thai guards, Khmer bandits, and camp residents, were common occurrences (Kanter, 1995; Mattson, 1993). Refugees arrived completely unfamiliar with the Western biomedical model and health care system. Ultimately, the violence, torture, injury, malnutrition, famine, infectious disease, and poverty experienced during their flight from Cambodia, negatively impacted their physical and psychological health.

Literature Review

Cambodian Refugee Health Problems

Physical issues. Malnutrition, infectious diseases, and war injuries are common health problems of the world's refugees. Anemia, tuberculosis, hepatitis B, malaria, trichinosis, and intestinal parasites are found in high proportions among Southeast Asian refugees (Uba, 1992). Acquired brain damage due to physical trauma, torture, illness, and malnutrition, is another significant, yet under identified, health problem in refugee children (Westermeyer, 1991).

Westermeyer's (1991) research on malnutrition, infection, and brain damage among refugee children is quite salient to school nurses and special educators working with Cambodian refugee children. Through illustrative case histories he demonstrated that even after resettlement, continued malnutrition caused permanent brain damage and small stature. When cases of maladjustment at home and school occurred, permanent brain damage due to malnutrition or infectious disease was often identified as a contributing factor. Untreated ear infections caused hearing impairments. In addition, many refugee parents new to the skill of driving were involved in serious car accidents upon arrival in America. Their children, unrestrained by car seats or seat belts, suffered significant injuries, including traumatic brain injury.

Psychological issues. The socio-cultural and historical factors which place Cambodian refugee children at risk for mental health problems are extensive. War, violence, economic deprivation, torture, famine, and hardships of flight, not only impacted their physical health, but also wounded their spirits and psyches. Untold numbers of children witnessed the execution of family members. Children were separated from their families and sent to work in labor camps under conditions of starvation and physical and sexual abuse. Separation issues continued upon resettlement to the United States as children coped with the deaths and unknown whereabouts of parents and siblings.

Rumbaut (1991) described the psychological reaction to a refugee's experience of exit from country of origin, and entry to a new country, as one that may encompass "a long-term process of grief and mourning, heightened anxiety and depression, and an overwhelming sense of helplessness and hopelessness" (p. 58). Alternatively, he observed that some refugees believe their struggles have led to a sense of self-reliance, self-efficacy, and self-confidence.

At school, refugee children with mental health issues may present with learning disabilities, disruptive behavior, depression, and a wide range of somatic complaints (Gong-Guy, Cravens, & Patterson, 1991). Contributing factors to psychiatric disorders and maladjustment in refugee children include malnutrition, infection, physical neglect and abuse, racism and harassment, and identity conflicts (Westermeyer, 1991). Utilizing a stress model, Athey and Ahearn (1991)

identified trauma, loss, and severe deprivation as experiences which place refugee children at increased risk for "psychiatric morbidity, dysfunctional behavior patterns (such as suicide, drug and alcohol abuse, or delinquency) or 'incompetence' in love, work, or play" (p. 4).

Post-traumatic stress disorder (PTSD), depression, anxiety, and survivor guilt, are mental health problems that have been identified among Cambodian refugee children (Kinzie & Sack, 1991; Rumbaut, 1991). Carlson and Rosser-Hogan (1993) studied the mental health status of Cambodian refugees living in the United States ten years after they had fled Cambodia. Within a general population sample of 50 Cambodian refugees, 90% exhibited marked symptomology in one or more of the following: (a) PTSD, (b) dissociation, (c) depression, and (d) anxiety. Eighty percent suffered symptoms from three of the four symptom categories, 90% met the criteria in two or more of the categories. Overall, 86% of the respondents suffered from PTSD, and 80% suffered from depression.

A refugee child's lack of family support is a key risk factor that can significantly impact his or her psychological development. Family disintegration due to death and separation is often compounded by parents' inability to meet the emotional needs of their children due to their own psychological trauma and pain--an important reminder that the refugee child must be viewed within the context of family (Athey and Ahearn, 1991). Often refugee parents are dependent upon their children who are more adept at learning the language and ways of their new country. Such parent-child role reversals put refugee children at risk for having important childhood emotional needs unmet.

Culture is the "glue that provides a community with meaning, cohesion, and integration" (Athey & Ahearn, 1991, p. 14). The disintegrating refugee family structure lacks the support from traditional Cambodian culture, a universal protector of their past. Eisenbruch (1992) found that refugee children suffer "cultural bereavement" due to the loss of traditional cultural values and social structures.

Due to stigmatization of mental illness within the Southeast Asian culture, refugees tend to shun mental health services due to fear of damage to family reputation, fear of deportation, and fear that such information will be shared with government agencies and their ethnic community (Gong-Guy, Cravens, & Patterson, 1991). Somatization of depression and other psychological disorders is a common phenomenon among refugees (Chester & Holtan, 1992; Muecke, 1983). In a study of stress in Cambodian women, D'Avanzo, Frye, and Froman (1994) found that their expressions of stress were primarily somatic, and included headaches, shortness of breath, chest pain, and sleeping a lot. From the holistic view of many Cambodians, there is no separation of emotional state and physical symptoms. Cambodians may also attribute mental illness to possession of spirits or negative karma from past lives.

Traditional Cambodian Health Beliefs and Practices

Buddhist philosophy is a major influence in the Cambodian world view which values equilibrium and harmony in one's life. Behaviors which promote these values include the avoidance of confrontation and competition, gentleness, nurturance toward elderly and children, and peaceful coexistence (Frye, 1991). Cambodians view health as a state of equilibrium. When an imbalance occurs between energizing "hot" forces and calming "cold" forces, disequilibrium occurs leading to illness (Frye, 1990). The symptoms associated with disequilibrium are described as a state of internal "bad wind" and affect body, mind, and spirit (Frye, 1991).

Treatment of illness is aimed at the restoration of equilibrium through dermabrasive wind releasing or oppositional treatments. Wind releasing techniques include "coining" or "coin rubbing" which is believed to help the bad wind escape, thus restoring equilibrium. Coining is the practice of rubbing the skin with eucalyptus oil and a coin to create a reddened abrasion through which the bad wind escapes. The resultant bruising and marks have been mistaken as a form of child abuse by those unknowledgable of this Cambodian healing practice. Other wind releasing techniques include cupping and pinching. Massage is also used to treat illness (Kemp, 1985).

Another example of folk knowledge is the use of food to restore equilibrium. "Cold" states such as childbirth and respiratory ailments are treated with opposing "hot" foods such as meat,

salt, and wine. "Hot" states such as hypertension are treated with "cold" foods such as fruits and vegetables (Frye, 1990, 1991; Kemp, 1985; Muecke, 1983). Traditional medicines and herbal infusions may also be used. (See Table 1).

In addition to defining illness as a state of disequilibrium, Cambodians also believe in spiritual causes of illness, such as negative karma from previous lifetimes or spirit possession (Eisenbruch and Handelman, 1990; Kemp, 1985). Buddhist monks and "krous khmer", traditional folk healers, perform spiritual rituals and prayers in the temple and home to bring about healing. Monks and krous khmer may bless lustral water, into which Pali prayers are said. The water is then poured over a person in an effort to heal (Kemp, 1985; Kulig, 1994). Amulets and strings may be tied around wrists in order to "tie in the soul" so that it does not become lost. (Galanti, 1997; Kemp, 1985).

Transcultural Relationships

Over the last two decades there has been an increase in published studies on the health care beliefs and practices of different cultures. In addition, researchers have begun to focus upon the nature and meaning of nurses' experiences of the transcultural process. Murphy and Macleod Clark's (1993) descriptive study of the experiences of nurses working with ethnic minority clients revealed that nurses shared many common experiences and challenges. Communication barriers, lack of knowledge of different cultural ways and beliefs, and feelings of ineffectiveness in delivering holistic care, were identified as predominant issues. The nurses' desire to connect with clients in a therapeutic relationship and to provide culturally sensitive care was a common theme, often coupled with feelings of frustration and helplessness over the challenges encountered in the process. Those nurses who believed they had positive relationships with their patients, noted that it took patience and time to build those relationships.

The complex issues for psychiatric nurses counseling clients of differing cultural backgrounds were addressed by Wright (1991). Wright challenged psychiatric nurses to develop an authentic and realistic approach that takes into account cultural background, yet is "flexible enough to respond to the individual and not merely his/her cultural grouping" (p. 92). Wright

warned that responding to a person's culture alone, rather than to the individual, carried the danger of "losing the person" (p. 95). Awareness of cultural diversity combined with individualization of care has been supported throughout transcultural nursing literature (Ahmann, 1994; Mason, 1990)

Concepts of cultural sensitivity and multiculturalism have given way to a new view which sees transcultural nursing as a "reciprocal" process. By means of case studies Harry, Kalyanpur, and Day (1999) proposed a posture of cultural reciprocity for professionals working with ethnically diverse students with disabilities. They encouraged professionals to initiate a "two-way process of information sharing and understanding . . . that can be truly reciprocal and lead to genuine mutual understanding and cooperation" (p. 7). They urged professionals working with these students to serve as bridge between the culture of schools and the culture of diverse families, and to acknowledge the cultural values of equity, independence, and individuality embedded within the culture of special education.

Ethnocentrism

Increasing critical analysis of the cultural biases and assumptions within research designs, calls for culturally sensitive research. According to Henderson, Sampselle, Mayes, and Oakley (1992):

> Ethnocentrism, the belief that our own culture is normative, is deeply embedded in our assumptions. It is very difficult to recognize that our culture influences our beliefs and our values as well as our behavior. It is even more difficult to act on the understanding that other cultures' beliefs, values, and behaviors are of equal value. . . .The researcher is neither culture free nor a neutral observer. (p. 341)

Nurses must remain cognizant of the underlying cultural biases and assumptions that may be implanted within the research design of studies on adjustment and psychological being among Cambodian refugees. Welaratna (1993) challenged researchers to evaluate the successful adjustment of Cambodian refugees in resettlement according to Cambodian values, rather than prevailing American notions. Her writings contrasted the financially oriented American view of success, with the Cambodian view which is defined in terms of harmonious relationships with

family and adherence to Buddhist precepts of non-harming, compassion, and right speech. In addition, she demonstrated the imposition of Vietnamese values on Cambodian behavior, in studies which compare the adjustment of Cambodian and Vietnamese refugees.

Likewise, Catolico (1997) scrutinized the underlying value assumptions found in research regarding the psychological well-being of Cambodian women in resettlement. This yielded suggestions for researchers to evaluate the psychological well-being of Cambodian women with the concepts of "harmony and balance, that more accurately represent the Cambodian woman's perspective" (p. 82).

Conceptual Framework Underlying This Study

Health visiting is a term used in British nursing to describe the method of nursing care which focuses on health promotion through interaction with people and groups in the community setting. Dobson (1989) identified meaningful and creative conceptualization of care as crucial to the development of a fundamental knowledge base for the field of health visiting.

Dobson (1989) asserted that transcultural reciprocity is a core concept in the practice of transcultural health visiting. Dobson envisaged transcultural reciprocity as:

> An inter-cultural process rooted firmly in the reciprocation of cultural respect and understanding between health visitor and client. . . . Assuming a spiralling [sic] dimension through time as the health visitor-client relationship becomes increasingly collaborative, transcultural reciprocity is viewed as a process in which both client and practitioner participate on equal terms. (pp. 100-101)

Dobson created a schematic figure of transcultural health visiting which depicted transcultural and intracultural reciprocity as spiraling and intrinsic dynamics of the relationship between health visitor and client (see Figure 1). The relationship between transcultural health visiting education, transcultural and intracultural reciprocity, and the goal of transcultural health visiting, are clearly illustrated in this schema. The framework also demonstrates the differences between transcultural reciprocity (between health visitor and client of different cultural

backgrounds) and intracultural reciprocity (between health visitor and client of similar backgrounds).

Dobson (1991) viewed caring, collaboration, and creativity, as integral concepts and essential process skills within the repertoire of a nurse's clinical expertise. "Collaborating with the client as an equal, demonstrating in words, actions and sometimes silence a warm sense of caring, and being creative and imaginative in finding ways to interweave culture and care, are part and parcel of skilful [sic] transcultural nursing." (pp. 115-116)

Acknowledging the prevalent unicultural approach in health visiting, she invited nurses to examine their own ethnocentric biases in the delivery of care. Within the context of transcultural reciprocity, nurses are offered the opportunity to gain a cultural perspective individualized to the client and family. Dobson (1991) encouraged nurses to "emancipate themselves from their own cultural view and take a metaphorical step into their client's cultural world" (p. 103).

Origin of Inquiry

The primary author's own interest in the nature of the experience of caring for Cambodians grew out of her own practice in pediatric, school, and public health nursing. Whether in a hospital, health clinic, school, or home setting, interactions with Cambodians led to enlightening shifts in perspective and world view. It was this researcher's sense that transcultural reciprocity "fit" what happened between nurse and client and this awareness invited the question of whether transcultural and intracultural reciprocity could be identified in the reports of school nurses and Cambodian liaison personnel.

Research Problem

Cambodian refugee families and children suffered violence, torture, injury, malnutrition, famine, infectious disease, and poverty during the phases of pre departure and flight from Cambodia, and initial asylum and resettlement in the United States. These experiences caused profound harm to their bodies, minds, and spirits. The challenge of providing nursing care to Cambodians requires knowledge, understanding, and sensitivity to their unique refugee experiences and cultural beliefs.

Medical and nursing research regarding the physical and mental health issues of Cambodian refugees has increased substantially since their arrival. In addition, transcultural nursing knowledge continues to expand through investigation of themes, beliefs, and health practices of Cambodians. However, research was lacking which specifically focused on the evidence of transcultural reciprocity between nurses and Cambodian refugees.

Purpose

The purpose of this study was to explore the nature and meaning of school nurses' and Cambodian liaisons' experiences of caring for Cambodian refugee children and families, and to explore whether those meanings validated Dobson's (1989) conceptual framework of transcultural health visiting. Through reflection with school nurses and Cambodian liaisons in focus group interviews, insight into the concepts of transcultural and intracultural reciprocity as experienced in their relationships with Cambodian refugees was sought. It was hoped that examination of the groups' experiences of caring for Cambodian families could lead to a deeper understanding of the transcultural nursing process and offer insight and knowledge that foster authentic and culturally sensitive care.

Research Question

The principal question of this study was: What is the nature of a cross-cultural team's experience of caring for children of Cambodian refugee families? Related questions explored the experience using Dobson's (1989) conceptual framework of transcultural health visiting. When a cross-cultural team of school nurses and Cambodian liaisons provides care to children of Cambodian refugee families:

1. How do they describe their experiences?
2. How are cultural knowledge and respect reciprocated within relationships with Cambodian families?
3. How are intracultural and transcultural reciprocity manifested?
4. Is there a spiraling dimension to reciprocity as described by Dobson?

5. How do non-Cambodian nurses transcend cultural differences to establish meaningful and helpful relationships with Cambodian refugees?

Methodology

This qualitative study of health care workers' experiences of caring for children of Cambodian refugee families was based on data gathered through focus groups. Participants were members of a cross-cultural team that provides health care services in a school setting. This team included school nurses and Cambodian liaisons in a school district where the majority of the county's Cambodian community live.

A semi-structured interview guide was developed to (a) gather information about the nurses' and liaisons' experiences caring for Cambodians and (b) look for elements of their encounters that might corroborate Dobson's conceptual framework of transcultural health visiting. Questions were reviewed by two qualitative researchers. The guide was also reviewed by a Cambodian registered nurse to determine if there were questions that might be considered inappropriate or insensitive to Cambodian respondents.

Sample

A purposive sample of school nurses and Cambodian liaisons was recruited from a school district serving a large population of Cambodian children in California. Six of the district's eight nurses volunteered, as well as two of the three Cambodian liaisons. The liaisons included a health clerk and a community liaison. Initial contact and invitation to participate was made by phone or letter. Signed consent forms were obtained prior to conducting the focus groups. The school nurses had a range of 6 to 15 years of experience working with Cambodians. The Cambodian liaisons had lived in the United States for 16 and 24 years.

Human Subjects Considerations

San Jose State University's Human Subjects-Institutional Review Board gave approval for the study's research protocol. All information obtained from the participants was kept confidential. No names were used in data analysis. Audio tapes of interviews were physically identified by focus group number only. Tapes were kept in a locked box, separate from a list of participant

names. Only the authors and transcriptionist had access to the transcripts and tapes. The list of names and the audiotapes were destroyed at the end of the data analysis process. Special consideration was given to the Cambodian liaisons and to issues of confidentiality. All participants consented to audiotaping, though they were given the option of not being taped.

Setting and Data Collection

Two of the authors, one a non-Cambodian school nurse and the other a Cambodian registered nurse, conducted the focus groups using semi-structured interview guides. The focus groups lasted between 1 1/2 to 2 hours. The focus group with the Cambodian liaisons was held in the non-Cambodian school nurse's home. It was moderated by the Cambodian registered nurse with the assistance of the school nurse. Two days later, the focus group with the school nurses was held in a conference room at their school district's main offices. The group was moderated by the school nurse author, with the Cambodian nurse serving as assistant moderator.

Cambodian refreshments and tea were served at the beginning of each group. The importance to Cambodian women of a welcoming and friendly time for interacting, before addressing formal topics in gatherings, has been found to be crucial to the development of trust (Kelly et al., 1996). Therefore, a full half hour was allowed for becoming acquainted and socializing with the Cambodian liaisons before the focus group began. The focus group interviews were conducted in English, although at times the Cambodian liaisons would share the Khmer words for certain health practices or illnesses. If there were no corresponding words in English, they would attempt to briefly explain in Khmer to the Cambodian nurse moderator. A monetary gift was given to each participant as a symbol of appreciation for their time.

Data Analysis Procedures

Focus groups and moderator debriefing sessions held immediately afterwards, were tape recorded and field notes were reviewed. All tapes were transcribed verbatim. Transcripts were compared with tapes for accuracy. Tapes were listened to and transcripts were reviewed several times by the moderators individually and together. The data were then grouped and categorized into

emergent issues and themes, and also reviewed in light of Dobson's conceptual framework of transcultural health visiting.

Findings

The findings will be discussed in relation to the three elements of Dobson's (1989) schema: (a) transcultural health visiting education, (b) transcultural health visiting, including transcultural and intracultural reciprocity, and (b) the goal of transcultural health visiting. Emergent themes and issues will be addressed.

Transcultural Health Visiting Education

The three components of education include (a) development of transcultural health visiting knowledge, skills, abilities, practices, (b) collection and analysis of data on client's ethnic identity and background, and (c) enhancement of intra-cultural relationships and establishment of inter-cultural relationships (Dobson, 1989). The findings in this section will address the ways in which the participants developed and utilized their transcultural knowledge and interpersonal skills.

Cambodian liaisons: Developing and using transcultural knowledge and skills. The Cambodian liaisons shared experiences which reflected their skill in interacting with Cambodian families at school and on home visits. The liaisons individualized their care based upon family history, background, and education. One liaison advised,

> First, I think you should find out about the family. Is it a new arrival? How many years have they been here? . . . It could be a lot different for a new arrival, [than for one that's been here for] two to three years.

They noted that their approach might be more direct with a less educated parent in order to convey their message. "I already know this family, what I can say, what tone, what I can stress, when I can be a little harder." The liaison described some of the less educated families as not knowing what to do in a given situation, and therefore, wanting specific direction. The liaisons demonstrated the various tones and gestures they might use with parents: a very soft and polite tone versus a louder, authoritative tone accompanied by emphatic hand gestures.

As the liaisons described their interactions with families, their interpersonal skills became apparent. They described the art of gentle probing with Cambodians who are hesitant to share their problems, and the ability to keep reaching out even though families don't respond. They spoke of how often families may react with anger when they are contacted by the liaisons because they think that such contact implies that their child is in trouble. In Cambodia, if a teacher contacted the parent, it was because the child had done something wrong. One liaison described a common response when she phones a parent. "The phone rings, and 'Hello'. . . . They'll be so rude! But that's the way they are. So they say, 'What's going on with my kid?! You blame the parent again?'" The other liaison continued,

> You have to understand. . . . They're frustrated. They don't know how to help their children. And, if you would say, (softly) "Why don't you come in and meet with us. We'll figure out what to do together. We'll have some ideas, we'll give you ideas if you need help". And then, they'll feel more comfortable and come. . . . When they're upset, they kind of cry for help. But they don't know how to ask for help, so they just show it in an angry way. So, if we don't know that, we think. . . . they're very angry. But then, if we know how to approach them, saying, "Look, we're trying to help your child. (voice becomes very gentle and quiet). If you come with us, we'll show you how." Then they're very nice. I always do that.

Their understanding of the psychological dynamics underlying the anger of Cambodian families was coupled with a willingness to reach out even in the face of such anger. They understood that beneath the anger, lay embarrassment, fear, anxiety, and tremendous family stress. They hoped the Cambodian families would finally trust that they cared.

> One liaison described her approach with families in which members suffered from PTSD: There's so much post-traumatic stress disorder and almost all the families are like that. Luckily, my family is okay... I have both my parents. I was very lucky. And I guess I'm the luckiest one, because most of my generation, when they came over, they either lost their father, their mom, or both. And I try hard to understand that. . . . I'm not going to be

> angry at them. . . . I'm not going to expect way over what I used to do. You know, I know everything that my family needs to do. But I'm not going to expect that from them. I can't. If I expect that from them I won't get anything from them. So be patient. Tell them what they need.

This liaison described her varied roles, and how she utilizes her life knowledge, rather than book knowledge:

> You kind of learn their behavior. In a way, like a psychologist. You have to be everything . . . nurse, psychologist, teacher, principal. You . . . . use all the knowledge you have to deal with them. . . . I mean, there's not college where we can attend class to learn about them.

The liaisons shared knowledge of Cambodian cultural ways of healing such as the coining, cupping, pinching, massage, and the use of medicinal herbs. They spoke of herbal wines used to restore a woman's health and beauty after giving birth, pomegranate leaves and bark for treatment of diarrhea, lemon grass for urinary problems, and juice squeezed from mint leaves to help with coughs. They also described a bitter herb called "tnam-maroy-mook" (medicine for a hundred symptoms) or "bondal-pech" (tip of a diamond). It is formed into little balls and swallowed with warm water. Some of the symptoms for which it is used include headache, chest pain, urinary problems, and arthritis. Medicines are brought back from Cambodia, and Chinese medicines may also be used.

The liaisons said that Cambodians tend to use Western medicine and Cambodian practices together. Antibiotics may not be taken for a full course, since once symptoms disappear, the medicine is stopped. They found that follow-up with parents regarding medication was often necessary. They also shared information about the spiritual healing practices of the elders at the temple and the roles of monks and krous khmer (traditional folk healers).

School nurses: Learning from Cambodians. For the school nurses, the Cambodian liaisons were the most important source of information about Cambodians and their culture. In describing a Cambodian liaison with whom she had worked, one nurse said, "I really learned from a master to

be sensitive." Other sources of information about Cambodian culture included workshops held at local colleges. "We had the refugee clinic and there were specialized nurses who had worked overseas, who gave workshops for us, and explained much of the history, and explained some of the conflicts which they bring over here." The nurses described the use of coining and herbs as part of traditional Cambodian health practices.

They also spoke of the pervasive effect of PTSD within the Cambodian families. One nurse described being in a public health office with other Cambodians after a school yard shooting had occurred in another part of the state. A gunman had come on campus and randomly shot at several children, many of them Cambodian.

> We sat around the table and the people spoke about the fear they had. . . . They thought they would come to the States and it would be much safer, and then suddenly, everything was turned upside down for them and the memories came back.

PTSD symptoms were also triggered when helicopters sprayed pesticides over the county in an effort to combat a fruit fly infestation. "The families would say, when the helicopters were flying around with the Malathion, that they had this big rush of memories from back home. . . . It was deeply embedded in them."

Knowledge of the Cambodians' historical background was helpful to the nurses in understanding their behavior. One nurse described the barriers she encountered when identifying children who needed glasses, especially with the first wave of immigrants that came arrived:

> I'd find somebody who needed glasses and it was a real barrier, because I was told people who wore glasses in Cambodia were murdered because it was a sign of being educated. . . Parents were very, very fearful when I'd say, "Well, we really need to get an eye exam, and get some glasses." Once I understood their fear and their anxiety, then I was able to make some inroads. But if you don't know that, you'd just really see a family as being uncaring and not wanting to follow through. Yet that was not the case at all.

The nurses spoke of the acculturation issues and intense generational conflicts in families. When the Cambodians initially came to the United States, "a lot of the things that we talked about

were food, medicines, behavioral things. But then later on, it seemed there was much more about the change and the pressure of the family structure." The nurses gave examples of students' Americanized ways, clashing with their elders' traditions. A nurse described eighth grade girls coming to her for help because their families were arranging marriages for them, but they wanted to continue on to high school.

As with the Cambodian liaisons, the school nurses found it important to understand the reasons behind a Cambodian's behavior.

> That's the first question you have to ask, "Why is this behavior taking place?" You can't judge everything from our standpoint. I try not to do that at all because otherwise we jump to assumptions and conclusions that are not the case. We have to be sensitive. . . . Each one is individual. You've got to ask the right questions.

Intra-cultural Reciprocity

With intra-cultural reciprocity (reciprocity between individuals of the same culture), (a) cultural frames of reference are similar and mutually understood, (b) cultural knowledge and respect are reciprocated, and (c) reciprocity assumes a spiraling dimension (Dobson, 1989). This spiraling quality was described both verbally and non-verbally in the interviews.

Cambodian liaisons: Reciprocity takes time, trust, and hospitality. The liaisons described Cambodians' hospitality and friendliness. They discussed the ways Cambodians reciprocated respect in their greetings and how they addressed each other. In Cambodian culture, people do not call each other by their first names unless they are the same age. For example, respect is shown by prefacing the name of a woman older than oneself with either Meng, meaning Auntie, or Bong, meaning Big Sister.

> Our people are usually very nice . . .They would greet anybody the same. To all people they're very polite. They always invite you to come into their home even though they don't know you. That's their nature. They'll say, "Please come on in. Come on in". . . . You greet them by saying, "How do you do? How are you?"

One liaison said, "Cambodians are really friendly. . . . But if we go unexpectedly, just knock on the door, they still greet you the same: 'Come in, please. . . . Have food, or have some fruit.' Or, they'll have something for you to take home."

The liaisons reciprocated cultural knowledge and respect through hospitality, observance of customs, and use of a soft voice. Smiling, joking, and teasing were other ways they used to express friendliness and to "warm up".

The liaisons emphasized the importance of allowing time for trust to grow. "They like being greeted, they like being friendly, first, before you start telling them about their child's problem. You've got to be friendly first." Even as Cambodians, it took time for them to establish trust with other Cambodians. "Trust is very important. If they trust you enough they'll come to you. And most of the time they'll come to us." "Sometimes they may not open up. So, be polite first, build friendship. . . . Sometimes it's too soon."

"But for the first time you stop for a home visit, maybe they're not open yet to share. They're saying, "I want to be polite. I want to be friendly, a good host, and invite them to come in." They also described families not sharing problems or asking questions until the visit was over.

> Most families during the home visit . . . aren't really open to asking questions until you get up and are on the way to the car. They think that it's not formal anymore, so [they say] "Can I ask you a question?" But they won't ask during the visit, only after you get up.

A liaison described approaching Cambodian parents as equals. "I approach them at their level. I don't make myself higher. I'm not making myself lower." This would fit in with Dobson's schema depicting the health visitor and client on equal ground. Connections with other Cambodians were also made through sharing pride in their cultural background. One of the liaisons shared her pride in the Khmer language with Cambodian students. "And I have a lot of Cambodian kids . . . . So I speak Khmer to them and they say, 'She speaks Khmer!' They were excited. They were so proud. And then they started telling me about their stories." The other liaison made many connections with the community through involving young people with the Cambodian New Year celebrations.

The liaisons expressed their care by going on home visits if a child was sick or having trouble at school. They would go because, "We wanted them to know us, that we care for their family, so that way they would start opening up to us."

The liaisons' efforts to keep reaching out, reflect Dobson's depiction of the onus being on the health visitor to establish and maintain reciprocity. Through continued effort to reach out, the liaisons attempted to send the message "We want to help, we care." They advised:

> Just try to reach out to them, no matter if they are angry at you. They'll see later on that you're not trying to harm them in any way. Just keep reaching out to them and then they will trust you.

The liaisons used hand gestures to indicate the circular route they took when interacting with Cambodian families. These gestures seemed to suggest the spiraling dimension of reciprocity as described by Dobson. "You have to warm up. You don't go straight to the point. It doesn't work that way. So you make sure that they're comfortable before you get to the point."

Once trust is established, the liaisons described the ways in which families reciprocated by expressing their care for the liaisons. They described Cambodian families bringing them jasmine flowers or "chompa", similar to what grew in Cambodia. "We kind of know everybody in the community. Sometimes they will bring her food, bring me food. . . . because we didn't have time to go to their house. That's how nice they are."

Transcultural Reciprocity

Using Dobson's framework, transcultural reciprocity (reciprocity across cultures) is fostered through the nurse's affirmative desire to bridge and transcend intercultural differences. Again there is evidence of a spiraling dimension to reciprocity.

School nurses: Reaching out across cultures through personal contact. The nurses found that the best way to connect with Cambodian families was through personal contact. Letters sent to parents, whether in English or Khmer, were not effective, since many parents cannot read either language. Home visits were one of the most effective ways of establishing a direct connection and expressing care for children and their families. Teaming together with the Cambodian liaisons, the

nurses demonstrated their ability to collaborate in providing services. "You really have to reach them directly. And pretty much the only way we have to do that is through our liaisons."

Cultural knowledge and respect were demonstrated in a variety of ways. The removal of shoes upon entrance to a Cambodian home was one way of conveying respect. Establishing a relationship by showing knowledge and interest in Cambodia was another. One nurse shared how she tried to connect with Cambodian school children .

> I have a couple of picture books on Cambodia. . . . I've had people shocked that I know where Cambodia is. . . . We could look at in on the map. It sounds very basic, but it's a way of making a connection. Especially with the students, they're like "Wow, it's a book on Cambodia." And then we talk about where their families are from. So, some type of personal connection.

Statements which suggested transcultural reciprocity included: "It's a two-way street", and "I just think we need to continually keep reaching to them and helping them with little baby steps. . . . we can help with this and we can help with that."

The nurses spoke of how it took time to build relationships and trust with their Cambodian families. They described a process of building upon previous encounters to gradually develop trust. One nurse talked of how she gave an earthquake preparedness program for the Cambodian community. The presentation . . .

> . . .Really helped with my working on other levels . . . because it was my . . . community that I was trying to reach. . . . I guess [after that] they saw me as a real, live person who was reachable, and so I was able to begin to work a little bit more on individual problems.

A nurse described a Cambodian mother reaching out to her by sending an American greeting card as a symbol of thanks for helping with a special education placement of her daughter.

> It was during the holiday time, and it had a poinsettia, and I opened it up and it said something about bereavement. But she, in her own way, had wanted to say, in a kind of Americanized way, "I want to thank you. You did something special for my family." It turned out she couldn't read English . . . but I surely got the message from her, and it was

in a very positive approach that she was trying to share. That was very powerful for me. Whatever our group had done had met the needs.

The nurse understood and appreciated the mother's attempt to reciprocate. "Even though we feel we might be walking on unfamiliar territory, I think that they're genuinely quite grateful for what we do for their kids."

Goal of Maximizing Health and Well-being: Letting Go of One's Own Views

Both the Cambodian liaisons and school nurses related the importance of providing care within the parameters of their Cambodian client's own cultural traditions. The Cambodian liaisons acknowledged differences between the very traditional beliefs of the elders in the community and the integration of Western medicine by the younger generation of Cambodians. According to the Cambodian liaisons one should never challenge the health and spiritual beliefs of Cambodian elders.

> You don't want to object to anything. Because, even though you're learning about nursing stuff, you don't want to go in the middle. . . . they're going to beat you up. (laughing.) You don't want to go and do that. You let them let it out. You don't go and say, "This is what I've learned in school." It's not going to work. . . . You don't go and cut them off. No way. They would get very upset.

The nurses recognized the need to suspend their own ethnocentric views. Providing care to Cambodians encompassed being flexible and able to let go of one's belief system: "If it's not hurting anything, support it, and leave it alone. Because we don't know. Who knows. None of us do."

Additional Issues and Themes

As participants explored their experiences caring for Cambodians, emergent issues encountered within the Cambodian community surfaced (see Table 2). Many of these issues, such as domestic violence and truancy, were psychosocial in nature and involved family and school relationships. A strong need for safety in both relationships and settings emerged. Participants

identified school and the temple as safe places for Cambodians to gather. Given their traumatic history it seems understandable that Cambodians are particularly aware of the need for safety.

Multifaceted Roles of Cambodian Liaisons: "We Want to Help Them in Any Way"

The invaluable and multifaceted roles of the Cambodian liaisons emerged as a dominant theme from the focus groups. They are much more than translators. In analyzing the data, 13 roles were identified (see Table 3). As an example, the role of protector emerged. One liaison said,

> We want them to trust us. And we want to help them in any way. We would never do anything to jeopardize them, their families, or their beliefs. We would never try to do that. If somebody tried to do that to them, we'd stop them.

These liaisons were deeply committed to their Cambodian families and community.

Cross-cultural teams are invaluable in their ability to reach out to culturally diverse communities. Leiper de Monchy (1991) asserted that:

> The cross-cultural team approach offers many advantages when working with refugee children who are in the process of integrating two worlds, their homeland and the adoptive country. . . . Teams can be a visible symbol of integration, with respect for both cultures. In addition they provide support and training to refugee paraprofessional staff whose expertise has come from experience rather than formal education in Western disciplines. (p. 170)

School and Home: "Stuck in the Middle"

Both liaisons often felt put on the spot when they had to explain and enforce school rules to Cambodian parents. Even though they were essentially translating the school administration's rules, parents would often get angry with the liaisons. They expected the liaisons to help them bypass some of the school regulations. The Cambodian community expected the liaisons to have the power to change or bend the rules.

> Many times I feel very frustrated because I know my people. They depend on me. And yet, I have to do what they (school staff) ask me to tell them. And I feel very frustrated. And I say "I wish I could help you, but I can't. I only work here." And they say "Yes,

> you work here. There's why you need to help us." So you get caught in the middle. You're like , "Oh my god, what am I supposed to do?!". . . . "You're Cambodian. Why can't you help us?!" We get stuck.
>
> The other liaison added:
>
> I'm not there to put people on the spot. It's so difficult. I feel bad right there. I cry in front of the parents. Because I know that when they get out, they're going to say that I didn't help them.

The liaisons feared what the disgruntled parents would say to other Cambodians in the community, because their reputation was important to them and they genuinely cared for these families. It appeared that the pressure and expectations of their own Cambodian community, when in conflict with the school, were a significant stressor.

Intergenerational Conflict: "It's Hard for the Kids"

Although the interconnectedness and interdependence among Cambodian families were identified as strengths by the participants, acculturated Cambodian youth often find the Cambodian community's infrastructure restrictive and confining. In addition, the liaisons described the sense of powerlessness parents encounter raising their children in the United States. "They feel that they've lost all that power now, so it's very hard to raise kids over here. . . . They don't speak English." In the words of one nurse, "The parent is really at the child's mercy." A liaison shared:

> In one family you could see two cultures. Some parents are still following the old culture at home. Sometimes if I know them well and we're friends, I'll say, "You know, it's hard for the kids to follow your culture. Don't forget that he is not Cambodian. I know in your heart you're a Cambodian family, but your kids are growing up here. . . . in a different community, a different society, different civilization and culture."

The Refugee Experience: "Left from the Dead"

In comparing Cambodian and Vietnamese refugees, a liaison pointed out the perceived differences:

> The Vietnamese families, the ones that come, those are the ones that are very brave and

> educated. They came over to start a life. But us, we're the refugees. It's a big difference. Us, it's like "left from the dead." They call it left from the dead. It's like nobody wants to kill you, you're dead anyway. You have no education, you can't start anything, so you might as well be "left dead".

Spiritual Healing: "It Lifts Your Spirits"

The liaisons explained the important role of the Buddhist temple in healing practices of Cambodians. "Spiritual things help them."

> That's why they call it spiritual. It lifts your spirits up. You believe it works, so your body strengthens to fight the infection. It's not a medical thing. The monks don't know anything about medical terms or what to do to your body. So instead, they use the spiritual thing to help them.

Other descriptions illustrated the importance of friends in the healing process: "Friend visits can be medicine. Because it lifts your spirits." and "When I was young, when I was sick, when some certain person that knows me or some person that I like came to visit, it helped me."

Cultural Strengths: "Carried Across the Ocean"

The Cambodian liaisons and school nurses identified several strengths in Cambodians, as displayed in Table 4. One nurse reflected on Cambodian dance as a cultural asset:

> The dancing stands out . . . [as] something that can be carried across the ocean. It's within their mind and their memory, and that can not be taken away from them. And so the elders, the people who have the skills, are working really, really hard to transfer that to the younger kids.

Discussion

Dobson's (1989) conceptual framework was a useful tool in understanding the experiences of school nurses and Cambodian liaisons who care for Cambodian refugee children and families. The participants shared their transcultural knowledge and described the varied ways they reciprocate cultural knowledge and respect in an effort to establish and enhance their connections with Cambodians. Their descriptions of interactions with Cambodians suggest the presence of

intracultural and transcultural reciprocity within their relationships. The school nurses and Cambodian liaisons highlighted ways that they supported traditional Cambodian health beliefs and practices. In light of the findings, it appears that in addition to transcultural skills and knowledge, transcultural attitudes, such as empathy, patience, sensitivity, and willingness to suspend one's own world view, are essential for making connections with Cambodian families. Though the focus of the research was on the experience of reciprocity, important insight was gained regarding psychosocial issues within the Cambodian community.

Implications for Nursing Practice

Reflecting upon the Cambodian liaison's statement that "Friend visits are good medicine", one can envision transcultural health visiting as good medicine also. Awareness of transcultural reciprocity and the importance of establishing trust can help guide nurses in developing meaningful relationships with Cambodian refugee children and families. Advice is best taken from the liaisons who said, ""Keep your friendly face to them." "Keep reaching out." and "Never give up."

Transcultural nursing care should be incorporated into all stages of the nursing process when caring for Cambodians. Assessment should include exploring the meaning of health with Cambodian clients, and planning should integrate their cultural beliefs and practices. Implementation must be creative and support the care constructs of Cambodian culture. Evaluation should include feedback of clients regarding health outcomes as seen from their cultural perspective and world view.

Given the recurrent theme of intergenerational conflict, efforts to strengthen Cambodian family bonds and cultural ties could promote healing at both the family and community level. In partnership with the Cambodian community, interventions that target Cambodian refugee children with direct services, as well as indirect services through support of their families, are needed. Schools have the opportunity to serve as a hub for a kaleidoscope of community programs such as English acquisition classes, parent education, job training, counseling, and health services.

Collaboration with others outside the school setting is vital in creating a cross-cultural team approach of coordinated and comprehensive service to Cambodian refugee children and families.

Planning of programs should involve Cambodian families, local county refugee health and mental health providers, Cambodian leaders in the resettlement community, religious leaders and traditional healers, and counselors form Cambodian cultural associations. An overall goal for programs should be the collaboration of resources and knowledge so that services from these groups and agencies could be developed in a holistic and integrated manner--incorporating traditional Cambodian folk healing, Buddhist practice, and Western psychology and medicine. Cross-cultural teams should include bilingual and bicultural professionals and paraprofessionals from the fields of health, psychology, and sociology, as well as Cambodian community liaisons and outreach workers. (See Table 5 for further recommendations from the Cambodian liaisons and nurses.)

Transcultural Reciprocity in the Research Process

The researchers expected to be studying transcultural reciprocity between participants and Cambodian families. However, transcultural reciprocity also occurred in the research process itself on different levels. Spiraling reciprocity was experienced between the Cambodian and non-Cambodian nurse authors. Transcultural and intracultural reciprocity were experienced in both focus groups as moderators and participants interacted. In the liaison focus group, the Cambodian moderator used the terms "Meng" and "Bong" when addressing the liaisons. As trust developed, sensitive topics such as domestic violence, child abuse, depression, PTSD, and family planning were brought up by the liaisons. At the end of that focus group, the liaisons extended an invitation to the moderators to come see the Cambodian New Year festivities, and they indicated that they wanted to "stay in touch". In the school nurse focus group, the nurses began asking the Cambodian research assistant questions about the local Cambodian community. During that interaction, one could directly observe the school nurses increasing their transcultural knowledge.

Validity and Reliability

Validity and reliability were sought through the moderators' encouragement of respondents to share their experiences honestly, and through solicitation of differing perspectives and viewpoints from within the focus groups. Validity was sought by asking the participants to share

stories of their actual experiences. Focus group research is not intended to generalize, but rather to understand a topic in an in-depth way (Krueger, 1998). Instead of generalization, nurses may want to consider Krueger's concept of transferability when reflecting upon the use of these findings in other settings.

Though Dobson's conceptual framework provided a basis for exploring the experience of school nurses, the attempt was made to keep questions open ended, in an effort determine whether nurses and Cambodian liaisons would describe some of the concepts related to transcultural and intracultural reciprocity. The framework of cultural reciprocity and its spiraling dimension were not put forth to the groups. Yet participants described experiences which seemed to indicate Dobson's spiraling concept of reciprocity existed in their encounters with Cambodians.

Limitations

In retrospect, serving Cambodian refreshments at the school nurse focus group, relayed the school nurse moderator's bias of transcultural interest and sympathy toward Cambodians. This may have limited what types of information and viewpoints were shared by the nurses. In addition, they may have been hesitant to share issues in the presence of the Cambodian nurse assistant moderator. This could also be true for the presence of the non-Cambodian school nurse assistant moderator with the Cambodian liaison focus group.

Recommendations for Further Research

There is a need for further research into the concept of transcultural reciprocity as experienced by nurses who work with Cambodian refugee children. Continued study in this area may yield information to help nurses establish meaningful relationships with Cambodian families and transcend cultural differences. The expression of transcultural reciprocity with families from other cultural backgrounds is also encouraged. Although there is a wealth of information regarding the psychological health of Cambodian refugee children, current information regarding their general physical health is lacking. Clinicians are in need of comprehensive studies which utilize Cambodian explanatory models, in addition to biomedical views. Involvement of Cambodians as co-researchers is also essential. According to Muecke (1992), "Participatory research is necessary

to help reduce the power differentials between researchers and refugees that silence the authentic voices of refugees."

Final Reflections on Transcultural Reciprocity

Transcultural reciprocity provides a realm of experience awaiting exploration by nurses. Health care workers who care for Cambodian refugees have the opportunity to bring their clinical expertise and cultural sensitivity to their encounters. In turn, Cambodian families may choose to share the wisdom of their unique history, life stories, health practices, and beliefs. Engagement in the spiraling dimension of transcultural reciprocity may uncover jewels of healing wisdom for those refugees and nurses who dare to participate.

The horror and pain that thousands of Cambodian refugee children experienced is at times beyond imagination. They witnessed the execution of family members, suffered torture and forced labor, and endured poverty and starvation. Such traumatic events in their life stories placed them at physical and psychological risk. Yet "risk is not destiny, and children can and do overcome adversity" (Athey & Ahearn, 1992, p. 4).

Just as we admire a beautiful lotus flower that blooms above muddy waters, so too can we behold the gentle, pure, and untouched nature of Cambodian refugee children rising above their painful past. As nurses we have the opportunity to respond to the pain of Cambodian refugee children from their own Buddhist perspective, which believes that great suffering offers us the opportunity to respond with great compassion.

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Figure 1 Transcultural health visiting--schema--Dobson

From Dobson, S. M. (1989). "Conceptualizing for transcultural health visiting: The concept of transcultural reciprocity". Journal of Advanced Nursing, 1989, 14, 97-102.

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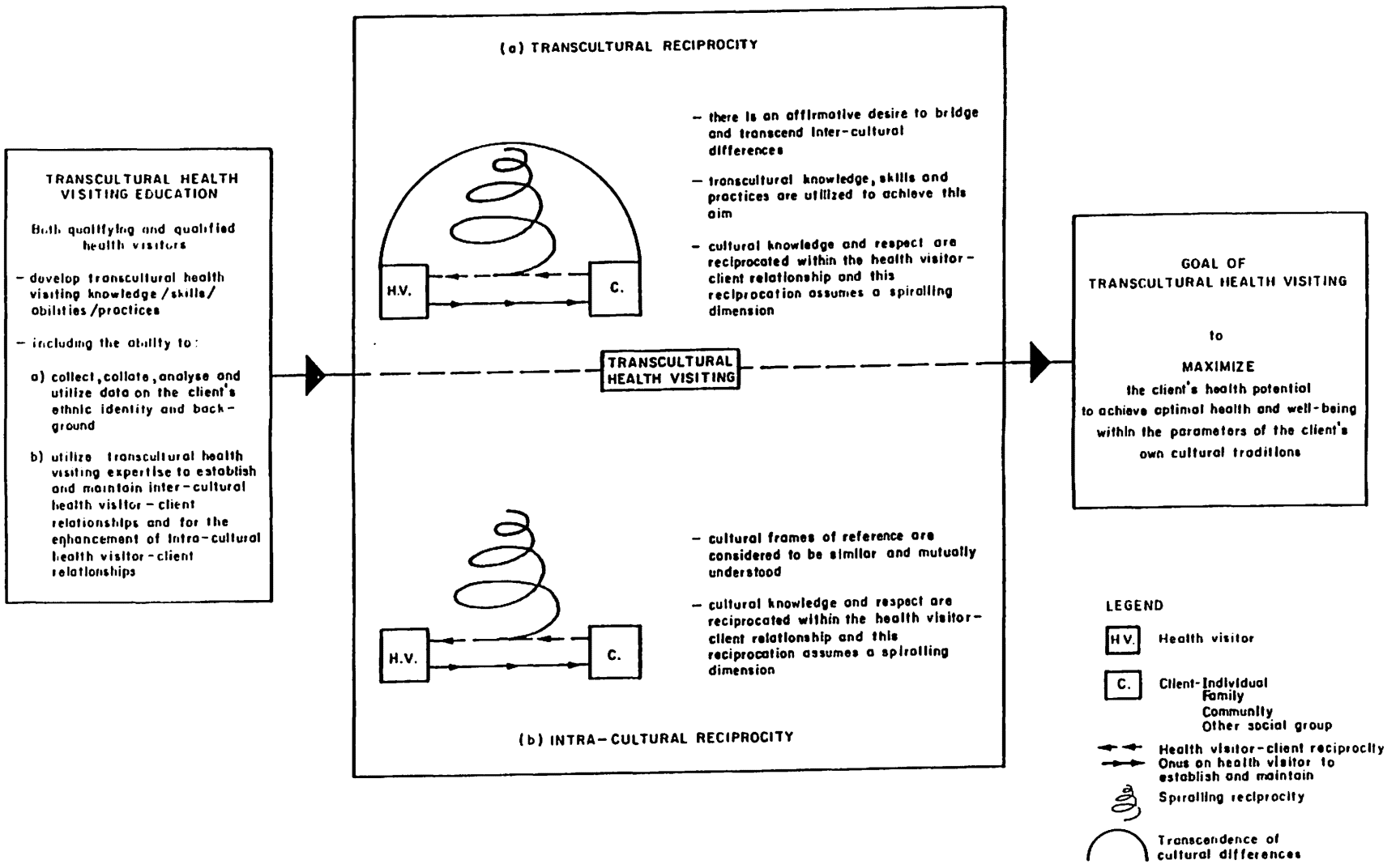
TRANSCULTURAL HEALTH VISITING EDUCATION
Both qualifying and qualified health visitors
- develop transcultural health visiting knowledge / skills / abilities / practices
- including the ability to:
a) collect, collate, analyse and utilize data on the client's ethnic identity and background
b) utilize transcultural health visiting expertise to establish and maintain inter-cultural health visitor - client relationships and for the enhancement of intra-cultural health visitor - client relationships
(a) TRANSCULTURAL RECIPROCITY
H.V.
C.
- there is an affirmative desire to bridge and transcend inter-cultural differences
- transcultural knowledge, skills and practices are utilized to achieve this aim
- cultural knowledge and respect are reciprocated within the health visitor - client relationship and this reciprocation assumes a spiralling dimension
TRANSCULTURAL HEALTH VISITING
H.V.
C.
- cultural frames of reference are considered to be similar and mutually understood
- cultural knowledge and respect are reciprocated within the health visitor - client relationship and this reciprocation assumes a spiralling dimension
(b) INTRA-CULTURAL RECIPROCITY
GOAL OF TRANSCULTURAL HEALTH VISITING
to
MAXIMIZE
the client's health potential
to achieve optimal health and well-being
within the parameters of the client's
own cultural traditions
LEGEND
H.V. Health visitor
C. Client - Individual
Family
Community
Other social group
Health visitor - client reciprocity
Onus on health visitor to establish and maintain
Spiralling reciprocity
Transcendence of cultural differences

Silence in the Forest

I heard it said over and over that,
"A child knows not what death is."

But at four,

Death was the singed smell of burned flesh;
where a burned log can easily be mistaken for a body.

Death was the motionless bodies;
with wide open eyes just staring.

Death was a pile of hand, arms, legs
and heads of all sizes, shapes and shades.

Crunched there silently in the brush,
She hugged her knees against her chest motionlessly rocking
and prayed that the pounding from inside would just stop,
because it could disturb the silence once again.

This poem was written by a Cambodian refugee who wished to remain anonymous.
Permission was granted by the author to print this poem.

(Insert at the beginning of article)

Table 1

Traditional Cambodian Health Beliefs and Practices

Beliefs	Practices
Health is a state of equilibrium	Dermabrasion
Disequilibrium/Illness is due to :	Oppositional treatments
Imbalance of hot and cold forces	Massage
Negative karma	Herbal medicine
Spirit possession	Spiritual healing
Symptoms are descibed as "bad wind" or loss of spirit	

Table 2

Emergent Issues Affecting Cambodian Families

Intergenerational conflicts	Isolation of elders
Post traumatic stress disorder	Gambling
Depression	Truancy
Intense family stress	Gangs
Domestic violence	Incompletion of high school
Child abuse	Teen parenthood
Large family size	

Table 3

The Multifaceted Roles of Cambodian Liaisons

Protector	Role model
Bridge	Motivator
Counselor	Catalyst
Health Educator	Doorway
Messenger	Behavioral Interpreter
Translator	Culture Bearer
Helper	

Table 4

Identified Strengths of Cambodian Refugees

Interconnectedness of extended families and community
Cultural arts and traditions
Resiliency
Survivorship
Caring and loving attitude toward children
Close bonds between young girls
Warmth and hospitality

Table 5

Recommendations for Nursing Practice

Know their history

Individualize care based on family's background and refugee history

Keep reaching out; trust takes time

Take a slow, friendly, non-direct spiraling approach

Gently probe

Suspend assumptions and world view

Look beyond the behavior to understandthe underlying dynamic

Support their cultural traditions and share your interest

Elicit their explanatory models for illness

Incorporate spiritual healing practices and the temple into delivery of health services

Encourage and mentor Cambodian role models

Provide health education re: family planning, nutrition, safety, routine check-ups

Assist with access to care

Provide support to parents and elders

Assess refugee risk factors as part of special education process

Monitor medications